APPENDIX 6

MISSISSIPPI DEPARTMENT OF HEALTH
APPLICATION FOR AN EMERGENCY CERTIFICATE OF NEED

The original application should be mailed or delivered to the following address:

Mississippi Department of Health
Health Planning and Resource Development Division
Attn: Emergency CON Application
570 East Woodrow Wilson
Jackson, MS 39215-1700

To expedite consideration, the application may be submitted by e-mail (Emergency.CON@msdh.state.ms.us) or facsimile (601-576-7530) followed by submission of the original to the above address.

I. APPLICANT/FACILITY INFORMATION

APPLICANT		
Applicant Legal Name:		
d/b/a (if applicable):		
Address:		
City:	State:	Zip Code:
County:	Telephone:	
Parent Organization (if applicable):		
CONTACT PERSON		
Name:	Title or Position:	
Telephone:	Fax:	
E-mail Address:		

1. Is the name of the existing or proposed facility different than the Applicant's legal name?
   (Instructions for electronically selecting check box: 1) place cursor over appropriate check box; 2) right click on mouse; 3) select Properties; 4) cursor or arrow down to Value; 5) change from false to true)

   ☐ Yes ☐ No

   If YES ⟶ Enter the facility information below.
   If NO ⟶ Continue to Section II.

FACILITY		
Facility Name:		
Facility Address:		
City:	State:	Zip Code:
County:	Phone:	

II. EVENT DESCRIPTION AND INCURRED LOSS OR DAMAGE

1. Description of Causative Event (check all that apply)
   - ☐ Fire
   - ☐ Natural Disaster (i.e. tornado, hurricane, etc.)
   - ☐ Water Damage
   - ☐ Failure of Equipment or Systems
   - ☐ Other
     a. If other, describe below.

2. Date of Event: _____

3. Description of Degree of Loss of Property (facility or equipment)
   Describe in as much detail as possible the incurred loss or damage. Documentation of the loss should be included with the application. If unavailable, documentation must be supplemented as soon as it becomes available.

4. Effects of Event on Operations of Health Care Services
   Describe in as much detail as possible the result or probable result of such loss or damage, including how such loss or damage would jeopardize the health and/or safety of the patients (temporary or permanent discontinuation of services, closure of facility, etc).

III. PROJECT DESCRIPTION

1. Describe all of the characteristics of the proposed project.

2. Applicant is proposing a change in services provided or facility capacity?

☐ Yes ☐ No

If YES ⟶ Answer questions 2a through 2d
If NO ⟶ Continue to question 3.

a. Applicant is proposing an addition or expansion of service(s)?

☐ Yes ☐ No

If YES ⟶ Explain below.
If NO ⟶ Continue to question 2b.

b. Applicant is proposing a change in existing bed complement or number of beds?

☐ Yes ☐ No

If YES ⟶ Explain below.
If NO ⟶ Continue to question 2c.

c. Applicant is proposing an upgrade in facility and/or equipment?

☐ Yes ☐ No

If YES ⟶ Explain below.
If NO ⟶ Continue to question 2d.

d. Applicant is proposing other types of changes in services provided or facility capacity?

☐ Yes ☐ No

If YES ⟶ Explain below.
If NO ⟶ Continue to question 3.

3. Applicant is proposing to relocate equipment and/or facility out of the current service area or county?

☐ Yes ☐ No

If YES ⟶ Explain below.
If NO ⟶ Continue to question 4.

4. Attach an itemized list of equipment and/or facilities to be repaired or replaced.

5. Complete the following table describing the estimated cost or expenditure contemplated. Attach a cost estimate from vendor or contractor.

		Estimated Cost
1.	Equipment Replacement	$
2.	Equipment Repair	
3.	Facility Replacement	
4.	Facility Repair	
5.	Other (specify)	
	Total	**$**

6. Anticipated date repairs or replacement will commence: _____

7. Anticipated date of completion of repairs or replacement: _____

8. Complete and sign the Certification page.

MISSISSIPPI DEPARTMENT OF HEALTH
CERTIFICATION

APPLICANT: _____

I (we) swear or affirm on behalf of _____, after diligent research, inquiry and study, that the information and material contained in the attached application for an Emergency Certificate of Need is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi Department of Health will rely on this information and material in making its decision as to the issuance of an Emergency Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department of Health may refrain from further review of the application and consider it rejected. **It is further understood that the applicant has fully disclosed in the application to the Department of Health any change in capacity.** It is further understood that if an emergency Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled or rescinded if the Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Department of Health. Furthermore, I (we) will furnish to the Department of Health a progress report on the proposal every six (6) months until the project is completed.

_____ _____
Signature Signature

_____ _____
Title Title

STATE OF _____
COUNTY OF _____

Sworn to and subscribed before me, this the _____ day of _____, 20____.

_____
Notary Public

_____
My Commission Expires